

The Warnock Committee

The Warnock Committee was established in July 1982 with the following terms of reference: "To consider recent and potential developments in medicine and science related to human fertilisation and embryology; to consider what policies and safeguards should be applied, including consideration of the social, ethical, and legal implications of these developments; and to make recommendations." It reported on 18 July 1984. Its members were Dame Mary Warnock, Mr Q S Anisuddin, Mr T S G Baker, Dame Josephine Barnes, Mrs M M Carriline, Dr D Davies, Professor A O Dyson, Mrs N L Edwards, Dr W Green-gross, Professor W G Irwin, Professor J Marshall, Professor M C Macnaughton, Dr A McLaren, Mr D J McNeil, Professor K Rawnsley, and Mrs M J Walker. It recommended that:

The licensing body and its functions

(1) A new statutory licensing authority be established to regulate both research and those infertility services which we have recommended should be subject to control.

(2) There should be substantial lay representation on the statutory authority to regulate research and infertility services and that the chairman must be a lay person.

(3) All practitioners offering the services we have recommended should only be provided under licence, and all premises used as part of any such provision, including the provision of fresh semen and banks for the storage of frozen human eggs, semen, and embryos should be licensed by the licensing body.

(4) Artificial insemination by donor (AID) should be available on a properly organised basis and subject to the licensing arrangements described in chapter thirteen, to those infertile couples for whom it might be appropriate. The provision of AID services without a licence for the purpose should be an offence.

(5) The service of in vitro fertilisation (IVF) should continue to be available subject to the same type of licensing and inspection as we have recommended with regard to the regulation of AID (see chapter four).

(6) Egg donation be accepted as a recognised technique in the treatment of infertility subject to the same type of licensing and controls as we have recommended for the regulation of AID and IVF.

(7) The form of embryo donation involving donated semen and egg which are brought together in vitro be accepted as a treatment for infertility, subject to the same type of licensing and controls as we have recommended with regard to the regulation of AID, IVF, and egg donation.

(8) The technique of embryo donation by lavage should not be used at the present time.

(9) The use of frozen eggs in therapeutic procedures should not be undertaken until research has shown that no unacceptable risk is involved. This will be a matter for review by the licensing body.

(10) The clinical use of frozen embryos may continue to be developed under review by the licensing body.

(11) Research conducted on human in vitro embryos and the handling of such embryos should be permitted only under licence.

(12) No live human embryo derived from in vitro fertilisation, whether frozen or unfrozen, may be kept alive, if not transferred to a woman beyond 14 days after fertilisation, nor may it be used as a research subject beyond 14 days after fertilisation. This 14 day period does not include any time during which the embryo may have been frozen.

(13) Consent be obtained as to the method of use or disposal of spare embryos.

(14) As a matter of good practice no research should be carried out on a spare embryo without the informed consent of

the couple from whom the embryo was generated, whenever this is possible.

(15) Where trans-species fertilisation is used as part of a recognised programme for alleviating infertility or in the assessment or diagnosis of subfertility it should be subject to licence and that a condition of granting such a licence should be that the development of any resultant hybrid should be terminated at the two cell stage.

(16) The licensing body be asked to consider the need for follow up studies of children born as a result of the new techniques, including consideration of the need for a centrally maintained register of such births.

(17) The sale or purchase of human gametes or embryos should be permitted only under licence from, and subject to, conditions prescribed by the licensing body.

Principles of provision

(18) As a matter of good practice any third party donating gametes for infertility treatment should be unknown to the couple before, during, and after the treatment, and equally the third party should not know the identity of the couple being helped.

(19) Counselling should be available to all infertile couples and third parties at any stage of the treatment, both as an integral part of NHS provision and in the private sector.

(20) In the case of more specialised forms of infertility treatment the consent in writing of both partners should be obtained, wherever possible, before treatment is begun, as a matter of good practice. Any written consent should be obtained on an appropriate consent form.

(21) The formal consent in writing by both partners should, as a matter of good practice, always be obtained before AID treatment begins. A consent form should be used and thoroughly explained to both partners.

(22) For the present, there should be a limit of 10 children who can be fathered by one donor.

(23) In cases where consultants decline to provide treatment they should always give the patient a full explanation of the reasons.

(24) The NHS numbers of all donors be checked by the clinics where they make their donations against a new centrally maintained list of NHS numbers of existing donors, which is to be held separately from the NHS donor register.

(25) There should be a gradual move towards a system where semen donors should be given only their expenses.

(26) In relation to egg donation the principles of good practice we have already considered in relation to other techniques should apply, including the anonymity of the donor, limitation of the number of children born from the eggs of any one donor to 10, openness with the child about his genetic origins, the availability of counselling for all parties, and informed consent.

(27) It should be accepted practice to offer donated gametes and embryos to those at risk of transmitting hereditary disorders.

(28) All types of "do it yourself" sex selection kits should be brought within the ambit of control provided by the Medicines Act with the aim of ensuring that such products are safe, efficacious, and of an acceptable standard for use.

(29) The use of frozen semen in artificial insemination should continue.

(30) There should be automatic five yearly reviews of semen and egg deposits.

(31) There should be a maximum of 10 years for the storage of embryos after which time the right to use or disposal should pass to the storage authority.

(32) When one of a couple dies that right to use or dispose of any embryo stored by that couple should pass to the survivor. If both die that right should pass to the storage authority.

(33) Where there is no agreement between the couple the right to determine the use or disposal of an embryo should pass to the storage authority as though the 10 year period had expired.

Service provision

(34) Funding should be made available for the collection of adequate statistics on infertility and infertility services.

(35) Each health authority should review its facilities for the investigation and treatment of infertility and consider the establishment, separate from routine gynaecology, of a specialist infertility clinic with close working relationships with specialist units, including genetic counselling services, at regional and supraregional level.

(36) Where it is not possible to have a separate clinic, infertility patients should be seen separately from other types of gynaecological patient, wherever possible.

(37) The establishment of a working group at national level made up of central health departments, health authorities, and those working in infertility, to draw up detailed guidance on the organisation of services.

(38) Consideration be given to the inclusion of plans for infertility services as part of the next round of health authority strategic plans.

(39) IVF should continue to be available within the NHS.

(40) One of the first tasks of the working group, whose establishment we recommend in 37, should be to consider how best an IVF service can be organised within the NHS.

Legal limits on research

(41) The embryo of the human species should be afforded some protection in law.

(42) Any unauthorised use of an in vitro embryo would in itself constitute a criminal offence.

(43) Legislation should provide that research may be carried out on any embryo resulting from in vitro fertilisation, whatever its provenance, up to the end of the 14th day after fertilisation, but subject to all other restrictions as may be imposed by the licensing body.

(44) It shall be a criminal offence to handle or to use as a research subject any live human embryo derived from in vitro fertilisation beyond that limit—for example, 14 days after fertilisation.

(45) No embryo which has been used for research should be transferred to a woman.

(46) Any unlicensed use of trans-species fertilisation involving human gametes should be a criminal offence.

(47) The placing of a human embryo in the uterus of another species for gestation should be a criminal offence.

(48) The proposed licensing body promulgates guidance on what types of research, apart from those precluded by law, would be unlikely to be considered ethically acceptable in any circumstances and therefore would not be licensed.

(49) Unauthorised sale or purchase of human gametes or embryos should be made a criminal offence.

Legal changes

(50) The AID child should in law be treated as the legitimate child of its mother and her husband, where they have both consented to the treatment.

(51) A change in the law so that the semen donor will have no parental rights or duties in relation to the child.

(52) Following the English Law Commission, that it should be presumed that the husband has consented to AID, unless the contrary is proved.

(53) The law should be changed so as to permit the husband to be registered as the father.

(54) Legislation should provide that when a child is born to a woman following donation of another's egg the woman giving birth should, for all purposes, be regarded in law as the mother of that child, and that the egg donor should have no rights or obligations in respect of the child.

(55) The legislation proposed should cover children born following embryo donation. (See recommendations 53 and 54).

(56) Legislation should be introduced to render criminal the creation or the operation in the United Kingdom of agencies whose purposes include the recruitment of women for surrogate pregnancy or making arrangements for individuals or couples who wish to utilise the services of a carrying mother; such legislation should be wide enough to include both profit and non-profit making organisations.

(57) Legislation should be wide enough to render criminally liable the actions of professionals and others who knowingly assist in the establishment of a surrogate pregnancy.

(58) It be provided by statute that all surrogacy agreements are illegal contracts and therefore unenforceable in the courts.

(59) Legislation should provide that where a person dies during the storage period or cannot be traced at a review date the right of use or disposal of his or her frozen gametes should pass to the storage authority.

(60) Legislation be introduced to provide that any child born by AIH who was not in utero at the date of the death of its father shall be disregarded for the purposes of succession to and inheritance from the latter.

(61) Legislation be enacted to ensure there is no right of ownership in a human embryo.

(62) For the purposes of establishing primogeniture the date and time of birth and not the date of fertilisation shall be the determining factor.

(63) Legislation be introduced to provide that any child born following IVF, using an embryo that had been frozen and stored, who was not in utero at the date of the death of the father shall be disregarded for the purposes of succession to and inheritance from the latter.

The report contains three expressions of dissent. A leading article appears on p 207.

What is the toxic substance that gives the crab apple like fruit of the tropical manchineel tree its poisonous property?

The manchineel tree referred to is most probably *Hippomane mancinella* L (fam Euphorbiaceae), otherwise known as the beach apple. It occurs in tropical America, usually near the sea, but has been introduced into other tropical areas around the Indian Ocean.¹ Its toxic action is undoubtedly attributable to huratoxin, mancinellin, and related tiglane and daphnane diterpenoid esters.² These compounds are present in the latex (sap) of the tree, and are responsible for irritation of the skin and mucous membrane. Applied externally, the fruit will cause a severe, erythematous, oedematous, and bullous dermatitis or keratoconjunctivitis. Taken internally, purgation and associated gastrointestinal symptoms may be expected.¹ There are conflicting reports concerning the toxicity of the fruits in man.¹ This may reflect a variation in the concentrations of the toxic principles with the development and maturation of the fruit. Feeding the fruits to rats and rabbits has failed to produce obvious signs of toxicity, but intraperitoneal injections of extracts of the fruits resulted in death.³ Irritation of the skin could not be reproduced in animals,³ but this may have been a consequence of the method used; huratoxin and mancinellin are irritant in the mouse ear irritation assay.²—RICHARD J SCHMIDT, lecturer in pharmacognosy, Cardiff.

¹ Morton JF. Poisonous and injurious higher plants and fungi. In: Tedeschi CG, Eckert WG, Tedeschi LG, eds. *Forensic medicine*. Vol 3. *Environmental hazards*. Philadelphia: Saunders, 1977:1456-1567.

² Adolf W, Hecker E. On the irritant and cocarcinogenic principles of *Hippomane mancinella*. *Tetrahedron Lett* 1975;19:1587-90.

³ Carroll MN, Fox LE, Ariail WT. Investigation of the toxic principles of *Hippomane mancinella* L. III. Toxic actions of extracts of *Hippomane mancinella* L. *Journal of the American Pharmaceutical Association* 1957;46:93-7.